Preliminary Comments Development Team (PCDT) Presentation:

Addressing the Needs of High-Cost Patients with Complex Chronic Conditions or Serious Illnesses in Population-Based Total Cost of Care (PB-TCOC) Models

Walter Lin, MD, MBA (Lead)
Lawrence (Larry) R. Kosinski, MD, MBA
Terry (Lee) Mills Jr., MD, MMM
Lindsay K. Botsford, MD, MBA

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Objectives of This Theme-Based Meeting

- Discuss characteristics of high-cost patients with complex chronic conditions or serious illnesses and the disproportionate impact these patients have on Medicare spending
- Understand challenges and approaches related to improving care for high-cost patients with complex chronic conditions or serious illnesses
- Identify opportunities for optimizing the use of post-acute care, palliative care and end-of life care in population-based total cost of care (PB-TCOC) models
- Discuss performance measures applicable for high-cost patients with complex chronic conditions or serious illnesses

Note: PTAC is using the following working definition for PB-TCOC models: A PB-TCOC model is an Alternative Payment Models (APM) in which participating entities assume accountability for quality and TCOC and receive payments for all covered health care costs for a broadly defined population with varying health care needs during the course of a year (365 days).

Context for This Theme-Based Meeting

- PTAC has received 35 proposals for physician-focused payment models (PFPMs).
- PTAC has deliberated on the extent to which 28 proposed PFPMs met the Secretary's 10 regulatory criteria.
  - At least 13 PTAC proposals included components related to addressing the needs of patients with chronic conditions and/or serious illnesses
  - The Committee found that 7 of these proposals met Criterion 7 (Integration and Care Coordination)

Agenda

Background

Characteristics of High-Cost Medicare Beneficiaries

Challenges and Opportunities for Caring for Patients with Complex Chronic Conditions or Serious Illnesses

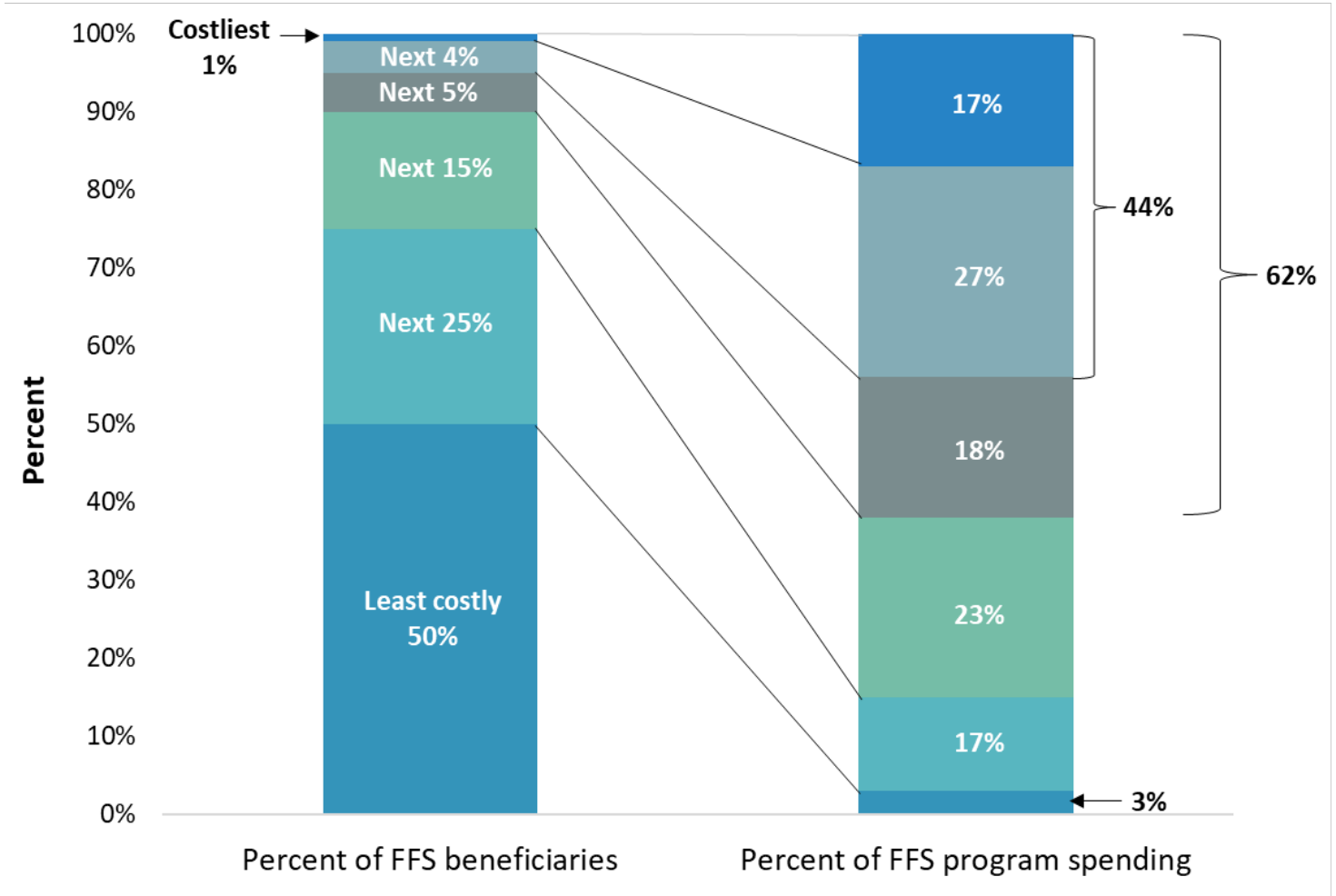
Performance Measures, Financial Incentives, and Payment Models

PTAC's Working Definitions of Patients With Complex Chronic Conditions or Serious Illnesses

- **Patients with complex chronic conditions** are patients with more than one morbidity, chronic condition, and/or comorbidity (lasting 12 months or more) who usually require a high complexity of treatment involving multiple health care providers across different specialties and settings.
- **Patients with serious illnesses** are patients with advanced illness and patients who are in their last years of life.
- *In addition to their chronic medical conditions, these patients may also experience acute events that can affect their health care needs.*

Concentration of Costs Among Medicare Beneficiaries

- A small proportion of Medicare beneficiaries account for a large proportion of Medicare fee-for-service (FFS) spending*
  - 1% of beneficiaries account for 17% of FFS spending
  - 5% of beneficiaries account for 44% of FFS spending
  - 10% of beneficiaries account for 62% of FFS spending
- Meanwhile, 50% of beneficiaries account for 3% of FFS spending



Source: Adapted from MedPAC. A Data Book: Health Care Spending and the Medicare Program. July 2023. Analysis of 2020 Medicare Current Beneficiary Survey.

* Based on 2020 Medicare Current Beneficiary Survey data

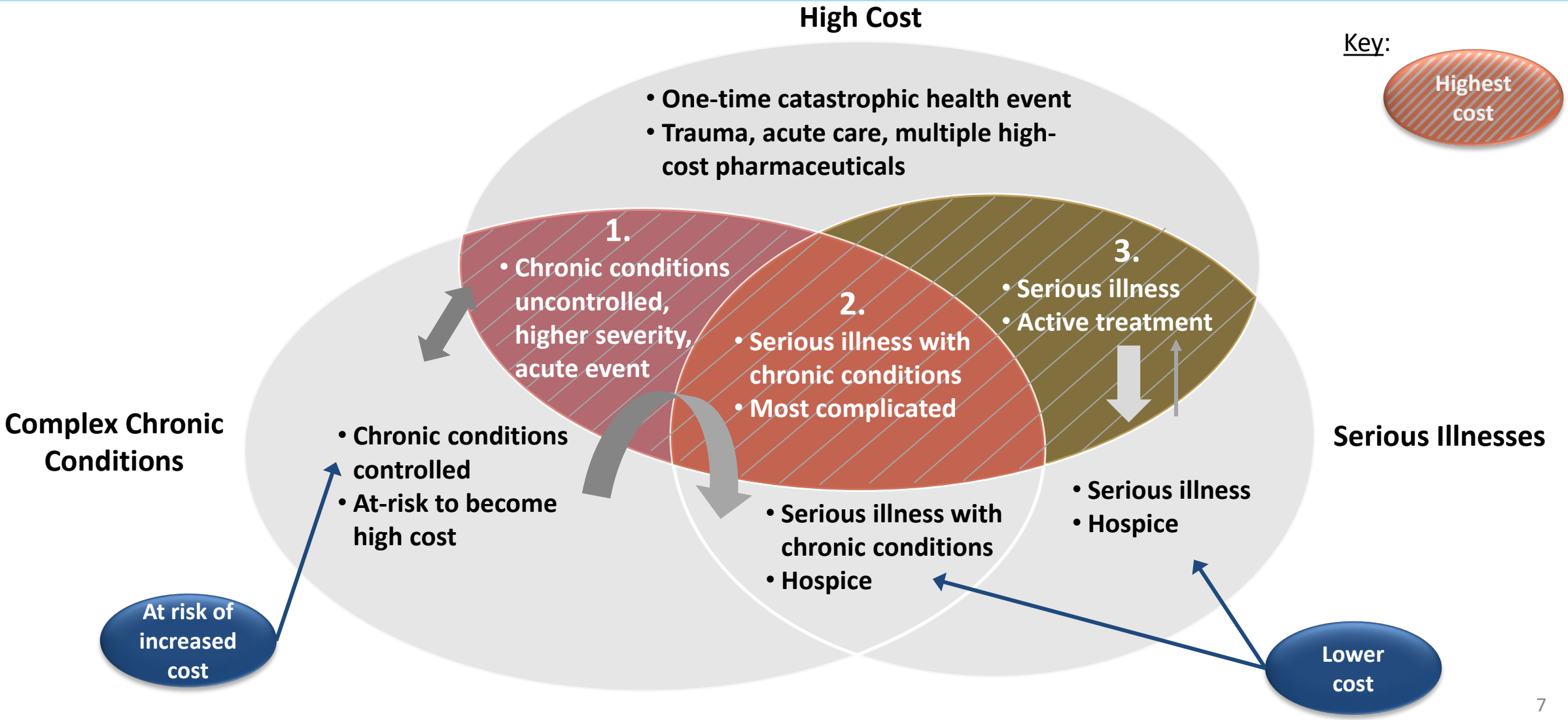
Many Beneficiaries with High Medicare FFS Spending Have Complex Chronic Conditions or Serious Illnesses

- High-cost patients may be classified into three health status categories:

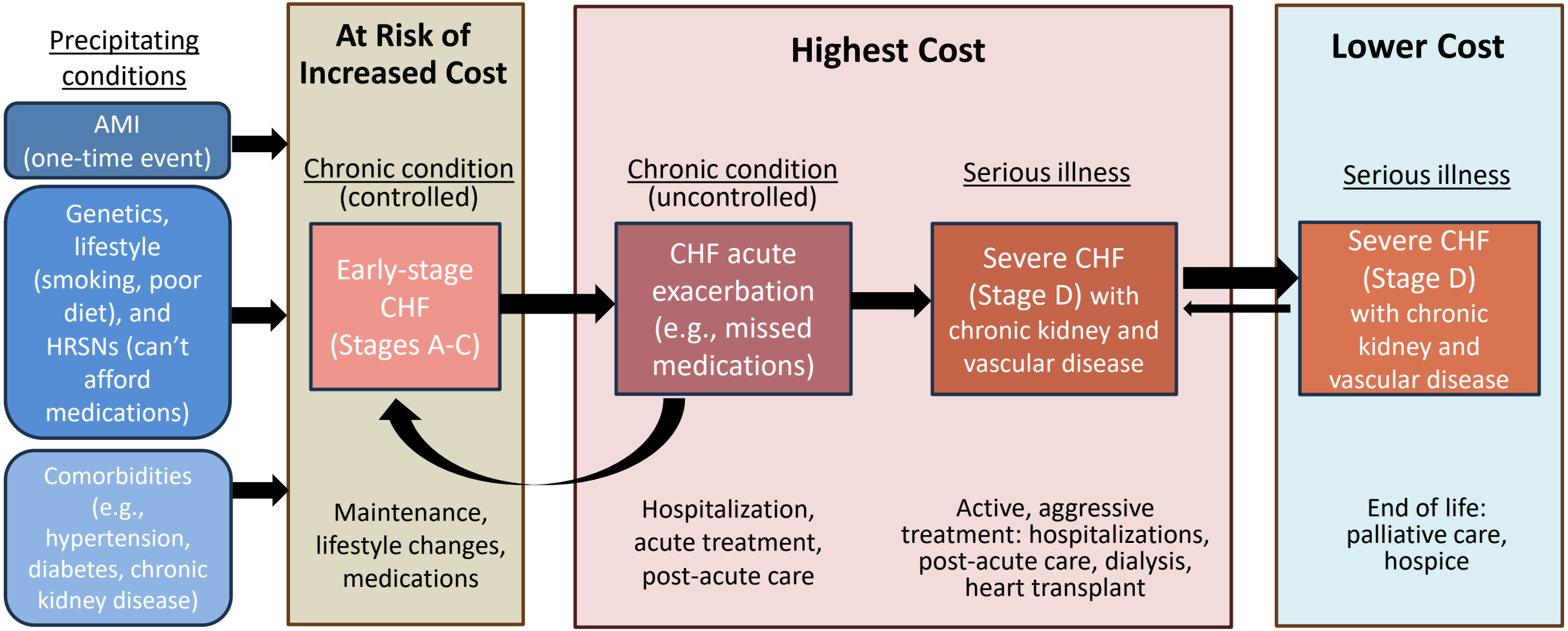
Category	Examples
Complex Chronic Conditions (controlled or uncontrolled)	More than one complex condition such as late effects of stroke, diabetes, hepatitis, obesity, non-healing complex wounds, HIV/AIDS, chronic obstructive pulmonary disease (COPD), mental illnesses
Serious Illnesses	End stage renal disease (ESRD), advanced heart failure, advanced liver disease, late-stage cancer
Experience a One-Time Catastrophic Health Event*	Sepsis, stroke, acute myocardial infarction, acute cancer, major trauma (e.g., from traffic accident)

* Includes patients who experience major trauma, sudden life-threatening illness, new diagnosis in complex disease or acute medical condition.

Relationship Between High-Cost Beneficiaries and Those With Complex Chronic Conditions or Serious Illnesses



Patient Care Journey Example: Congestive Heart Failure (CHF)



Potentially Preventable Spending Among High-Cost Beneficiaries

- The majority of potentially preventable health care spending* (72%) is among high-cost beneficiaries**
  - Some examples of potentially preventable events include congestive heart failure, bacterial pneumonia, COPD, and diabetes short-term complications
  - The most common care settings for potentially preventable spending among high-cost beneficiaries are inpatient (58%), physician services (22%), and skilled nursing facilities (11%)
- Four out of ten high-cost beneficiaries (44%) had at least one potentially preventable event
  - Patients with the highest percentage of preventable spending include those who are seriously ill, frail, both seriously ill and frail, or have serious mental illness

* Potentially preventable utilization includes preventable emergency department (ED) visits, preventable hospitalizations, and unplanned readmissions.

** Based on 2014 data

Agenda

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Performance Measures, Financial Incentives, and Payment Models

New ASPE Analysis of Medicare FFS Beneficiaries with the Highest Parts A and B Spending

Goals

- ❑ Examine trends in beneficiaries accounting for the highest Medicare Part A and B spending in Medicare FFS
- ❑ How often do FFS beneficiaries with high spending switch within and from the top spending decile?

Sample

- ❑ Beneficiaries continuously enrolled in Medicare FFS Part A and B and no Part C (Medicare Advantage), allowing death in each study year.
- ❑ Total spending includes both the Medicare payment and the beneficiary out-of-pocket (OOP) payment.

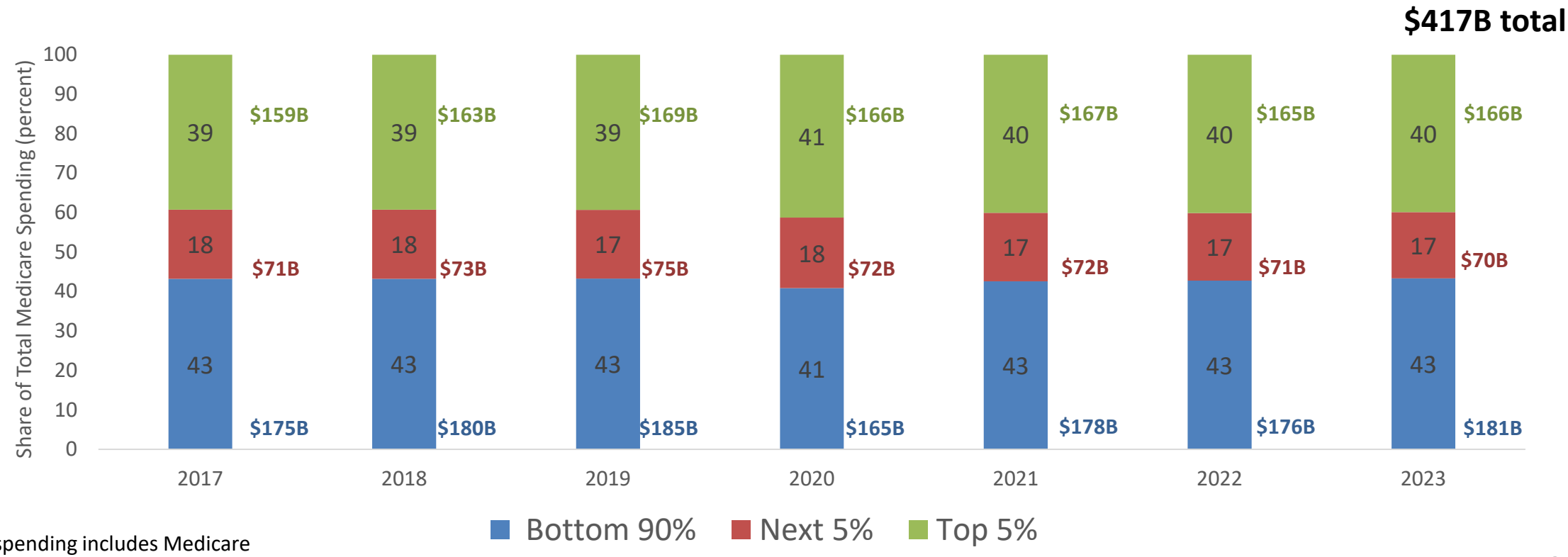
Year	Total Spending ($B)	N Beneficiaries (M)	Per Capita Spending
2017	$405.9	30.4	$13,373
2018	$416.2	30.1	$13,830
2019	$428.6	29.9	$14,351
2020	$402.9	29.0	$13,878
2021	$416.6	28.1	$14,799
2022	$412.5	26.9	$15,334
2023	$417.3	25.7	$16,223

Note: does not include Part D spending

Based on PTAC Commissioned Work - Analysis by ASPE and Acumen LLC

Percent of Medicare FFS Beneficiaries in Top Spending Categories Each Year, 2017-2023

- In 2023, the top 5% of FFS beneficiaries accounted for 40% of all Part A/B spending*, the next 5% accounted for 17% of all spending, and the bottom 90% accounted for 43% of all spending.
- The share of Medicare FFS spending associated with the top 5% has remained constant (39% to 40%).



* Part A/B spending includes Medicare program + beneficiary OOP.

Based on PTAC Commissioned Work - Analysis by ASPE and Acumen LLC

Trends in Average Per Capita Medicare FFS Spending*

Year	Top 1-5 percentile	Top 6-10 percentile	Overall
2017	$104,997	$46,888	$13,373
2018	$108,633	$48,431	$13,830
2019	$112,854	$49,954	$14,351
2020	$114,576	$49,570	$13,878
2021	$118,654	$51,219	$14,799
2022	$123,046	$52,442	$15,334
2023	$129,448	$54,405	$16,223
Annual Growth Rate	**3.6%**	**2.51%**	**3.27%**

In 2023, average per capita spending for the top 5% of FFS beneficiaries was **$129,000** compared to **$54,000** for the top 6-10%, and **$16,000** for overall FFS.

Between 2017-2023, the annual growth rate in Medicare FFS spending for the top 5% of FFS beneficiaries was **3.6%** compared to **2.5%** for the top 6-10%, and **3.3%** for overall FFS.

* Part A/B spending includes Medicare program + beneficiary OOP.

Based on PTAC Commissioned Work - Analysis by ASPE and Acumen LLC

Selected Characteristics of Medicare FFS Beneficiaries with the Highest Spending (2021)

	FFS	Top 5%	Top 6-10%
Mortality Rate (in CY)	**4%**	**22%**	**17%**
White	77%	76%	81%
Black	**8%**	**12%**	**9%**
Other	1%	1%	1%
Asian	3%	3%	2%
Hispanic	7%	7%	5%
Native American	1%	1%	1%
Unknown	2%	1%	1%
Dual	**13%**	**31%**	**25%**
Male	47%	49%	45%
Chronic Condition count	**3.0**	**8.0**	**6.9**

Mortality Rate: Significantly higher mortality rate for beneficiaries in top spending categories as compared to overall Medicare FFS

Black, Non-Hispanic: Higher proportion in the top 5% of beneficiaries compared to overall FFS

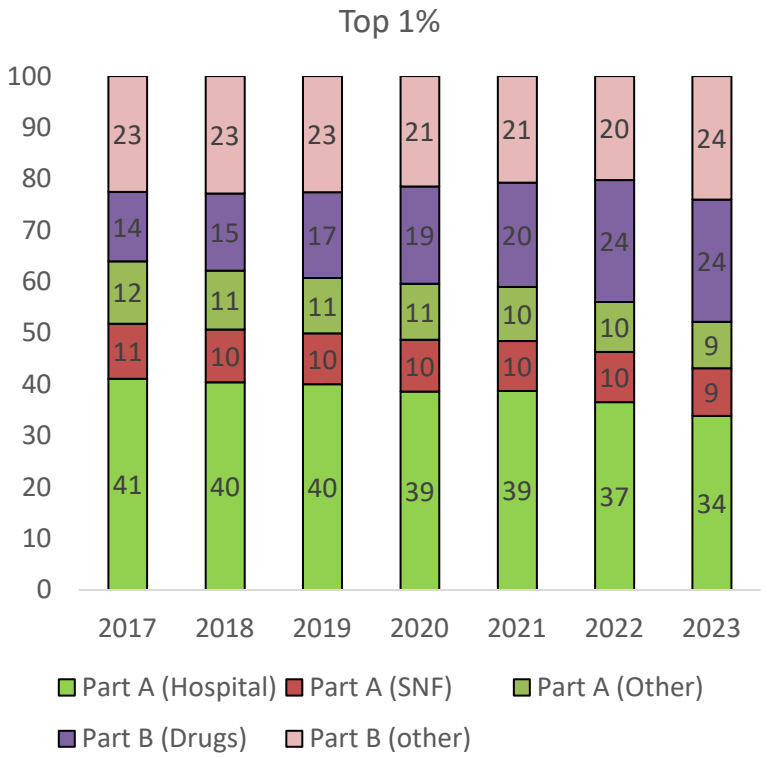
Duals: Disproportionately high share in top spending categories as compared to overall FFS.

Chronic Conditions: On average beneficiaries in accounting for the top 5% of spending had 8 chronic conditions as compared to 3 chronic conditions for beneficiaries in overall Medicare FFS.

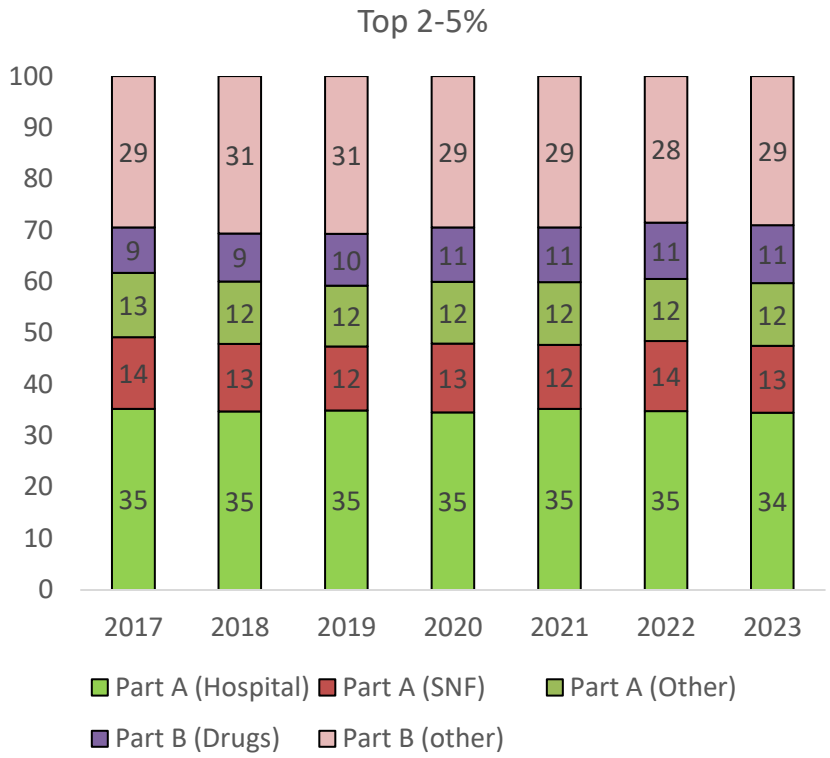
* White, Black, Other, Asian, Native and Unknown exclude Hispanic.

Based on PTAC Commissioned Work - Analysis by ASPE and Acumen LLC

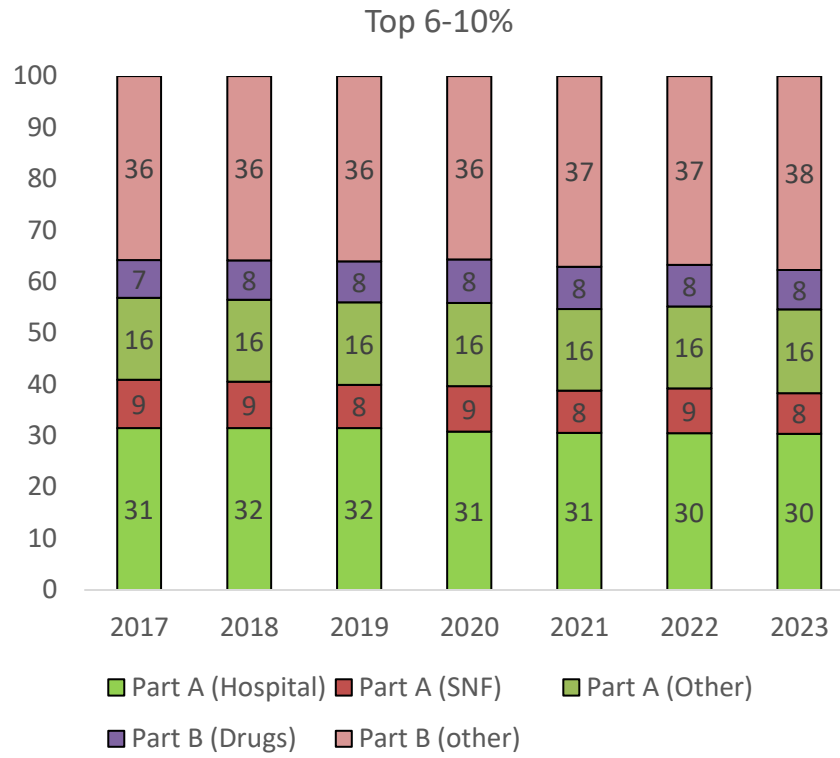
Spending Distribution by Type of Part A & B Services for FFS Beneficiaries in Top Spending Categories by Year



Part B (drugs) spending share increased by 10 percentage points



Part B (drugs) spending share increased by 2 percentage points

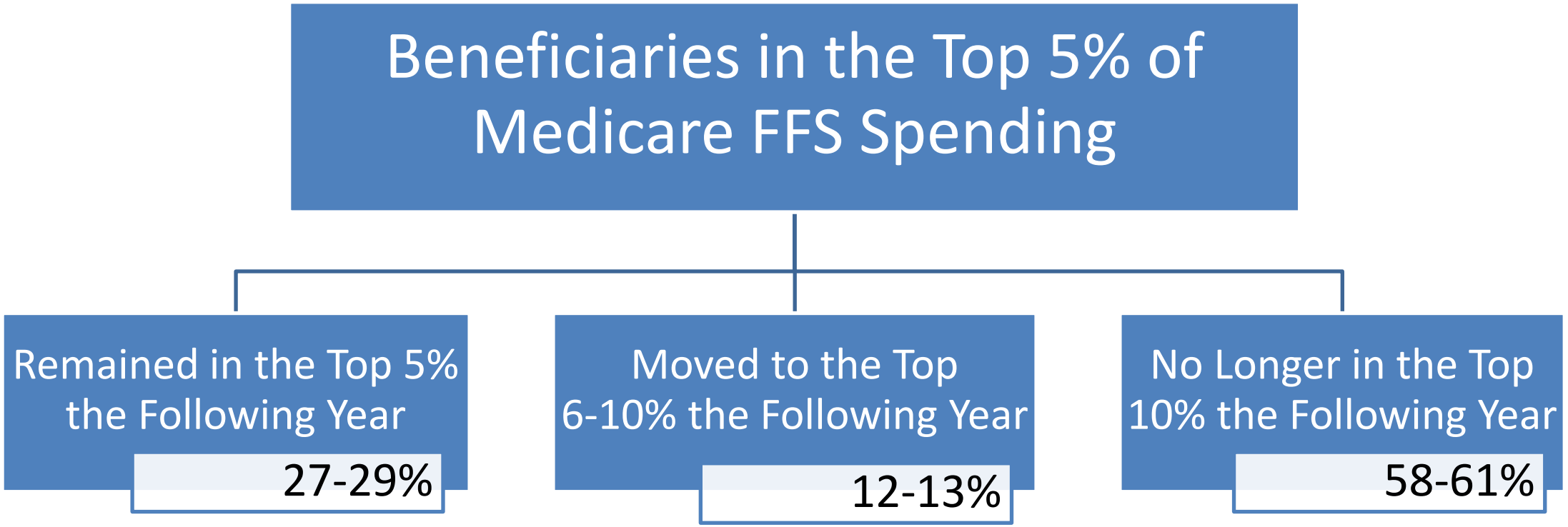


Part B (drugs) spending share increased by 1 percentage points

Note: Part B drugs include those that are typically provided in a clinician's office.

Based on PTAC Commissioned Work - Analysis by ASPE and Acumen LLC

Changes in Medicare FFS Spending Categories for Top Spending Beneficiaries Compared with the Previous Calendar Year (CY 2018-2023)



* This analysis includes FFS beneficiaries who were in the top 5% of Medicare spending (Part A/B + OOP) during the previous calendar year.

Based on PTAC Commissioned Work - Analysis by ASPE and Acumen LLC

Characteristics of the Top Spending Medicare FFS Beneficiaries by Changes in Spending Categories Compared With the Previous Year, 2023

Category	Top 5 % (2023)		
	Remained in Top 5%	Moved to 6-10%	No Longer in Top 10%
Average Age	72.8	75.8	76.9
Average # of Chronic Conditions	8.5	8.0	6.7
% Who Died	21%	24%	21%
% Living in Top 15% ADI Zip Codes	44%	41%	41%
% Dual-Eligible	34%	31%	26%
% Non-Hispanic Black	13%	10%	7%

More **than a quarter** of beneficiaries remain in the Top 5% one year later, **and over 40% remain in the Top 10% one year later.**

Beneficiaries in the Top 5% who remained in the Top 5% the following year had **more chronic conditions**; and **were more likely to be dually eligible**, **Non-Hispanic Black**, and to **live in zip codes with lower socioeconomic status**.

* % Who Died represents the % who died during 2023 (does not include the % who were in the Top 5% during 2022 and died during 2022). Top 15% ADI Zip Codes = Zip Codes with the highest Area Deprivation Index values.

Based on PTAC Commissioned Work - Analysis by ASPE and Acumen LLC

Agenda

Background

Characteristics of High-Cost Medicare Beneficiaries

Challenges and Opportunities for Caring for Patients with Complex Chronic Conditions or Serious Illnesses

Performance Measures, Financial Incentives, and Payment Models

Challenges Caring for High-Cost Patients and Patients with Complex Chronic Conditions or Serious Illnesses

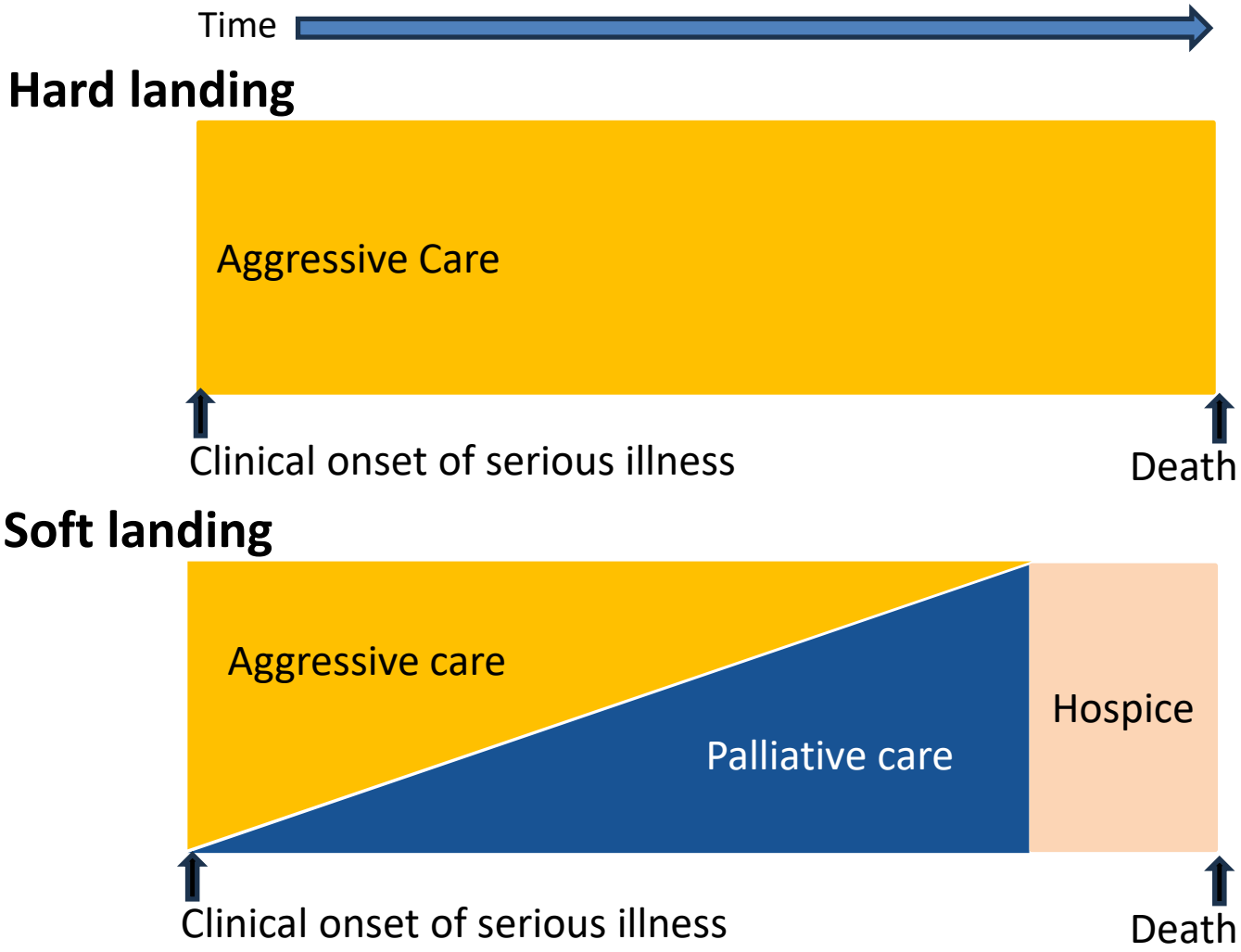
Patient identification and prevention	• Prospectively identifying patients with complex chronic conditions or serious illnesses, and those who may become high cost • Determining appropriate risk-stratification approaches • Composition of this cohort can change year-to-year
Provider challenges	• Identifying clear clinical guidelines and goals of care • Ensuring sufficient provider time with patients
Clinical care needs	• Addressing need for care coordination, specialty integration, and care transitions • Ensuring appropriate care needs (e.g., post-acute care, behavioral health, palliative care, hospice) are met • Implementing team-based care
Patient engagement	• Effectively engaging both patients and caregivers in delivery of care
Health equity	• Addressing health-related social needs and social determinants of health • Reducing disparities in outcomes

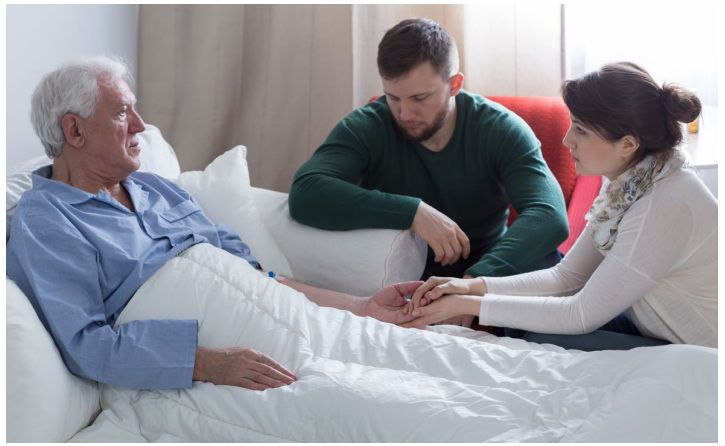
Opportunities for Improving Care and Achieving Cost Savings Among High-Cost Medicare Beneficiaries

- The greatest opportunities for improving care and achieving cost savings primarily exist among beneficiaries with complex chronic conditions:

Type of Beneficiary	Opportunity to Achieve Cost Savings
Complex Chronic Conditions	• Intensive outpatient team-based medical care and/or formal disease-management programs can improve health and reduce medical costs
Serious Illnesses	• Require expensive, ongoing treatment every year • Opportunity to improve quality and cost of care in many patients through an increased focus on palliative care and hospice

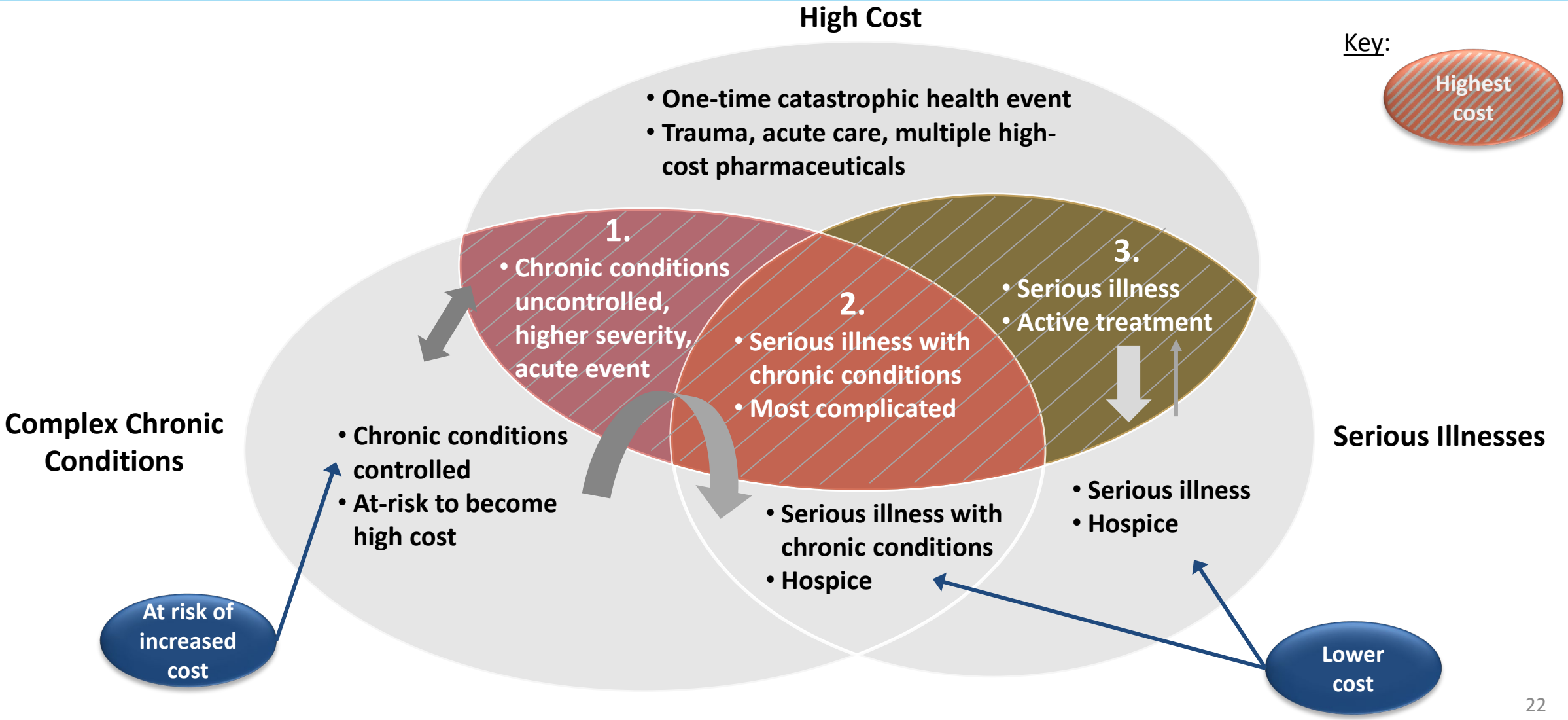
Two Trajectories for End-of-Life Care Among Patients with Complex Chronic Conditions or Serious Illnesses





Source: Trajectory diagrams adapted from Kamal A, Bull J, Kavalieratos D, Taylor D, Downey W, Abernethy A. Palliative Care Needs of Patients With Cancer Living in the Community. Journal of Oncology Practice, Vol 7, Issue 6. 2011.

Relationship Between High-Cost Beneficiaries and Those With Complex Chronic Conditions or Serious Illnesses



Important Objectives for Improving the Care of High-Cost Patients with Complex Chronic Conditions or Serious Illnesses

- Provide goals-concordant care.
- Delay progression of chronic diseases.
- Catch acute exacerbations early to enable outpatient treatment.

Strategies Used for Improving Care for the Highest Cost Patients with Complex Chronic Conditions or Serious Illnesses in CMMI Models

Patient Health Category	Strategies	CMMI Models/CMS Initiatives
1. Complex Chronic Conditions, Uncontrolled (Acute Exacerbations)	• Specialized multidisciplinary care teams • Care coordination • Patient navigation • Medication management	• Special Needs Plans (C-SNPs and I-SNPs) • Transforming Episode Accountability Model (TEAM)
2. Serious Illness, In Active Treatment	• Incentives to enhance care coordination • Person-centered approach to care • Delay progression of illness • Frequent goals of care discussions • Outpatient treatment of acute exacerbations	• Program of All-Inclusive Care for the Elderly (PACE) • ACO REACH High Needs DCEs • Medicare Advantage (MA) Value-Based Insurance Design (VBID) • TEAM
3. Serious Illness with Complex Chronic Conditions, in Active Treatment	• Person-centered assessments and care plans • Care coordination • Caregiver training, education, and support • Care navigation • Concurrent care services	• Kidney Care Models (Comprehensive ESRD Care, Kidney Care Choices, ESRD Treatment Choices) • Oncology Care Model

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Performance Measures, Financial Incentives, and Payment Models

Potential Performance Measures for Patients With Complex Chronic Conditions or Serious Illnesses

Measure Type	Population-Based	Episode-Based	Palliative/End-of-Life Care
Quality (Process)	% of patients with advance care planning discussions documented	% Transitional Care Management (TCM) visit completion rate	Hospice staff visits to patients in their final 3-days of life
Outcomes	% of patients who are satisfied with care received (PROM)	Healthy days at home*	% of seriously ill patients receiving hospice services at time of death
Utilization	Inpatient admissions per 1,000 (APK)	30-day re-hospitalization rate	% of patients admitted to hospice for <7 days or >1-year
Cost	Global cost per year	Medicare spending per beneficiary (MSPB)**	Global cost in last year of life

* Healthy days at home is a measure that is calculated by subtracting the following days from the total observation period of 31 to 60 days: mortality days; the total number of days spent in inpatient, observation, skilled nursing facilities (SNF), inpatient psychiatry, inpatient rehabilitation, and long-term hospital settings; and days with outpatient emergency department and home health visits.

**Medicare spending per beneficiary (MSPB) measures what Medicare spent for an episode of care at a hospital compared to all hospitals three days prior through 30 days after hospital admission.

Payment Methodology Challenges Related to Caring for High-Cost Patients and Patients with Complex Chronic Conditions or Serious Illnesses

Challenges	Description	Potential Approaches
Attribution / Assigning Accountability	• Multiple providers may be involved in patient care • Overlapping Episodes of Care	• Shared attribution by PCP and multiple specialists • Concurrent episode-based attribution
Aligning Incentives Across Settings	• Multiple settings may be involved in patient care	• Rewards for participation in a transition of care program • Increasing incentives for appropriate palliative care
Benchmarking	• Performance measure scores are misaligned when benchmarking to the general population	• Benchmarking against similar patient populations to allow for appropriate comparisons
Risk Adjustment	• Identification of a methodology that allows appropriate provider payment for this patient population	• Stratifying practices into risk groups using CMS-HCC risk scores for attributed patients • Using complexity tiers

Payment Methodology Challenges Related to Caring for High-Cost Patients and Patients with Complex Chronic Conditions or Serious Illnesses, Continued

Challenges	Description	Potential Approaches
Retrospective Reconciliation	• Difficulty of managing performance on a real-time basis	• Models that offer prospective payment methodologies (e.g., PBPM, bundled payments)
Issues Affecting Smaller and Rural Providers	• Small patient panel size	• Multi-payer models
Effective Payment Models	• Identifying effective payment models within a PB-TCOC model context	• Models that focus on and offer incentives for providing care coordination and transition services (e.g., care managers, coordinated care plans)

Summary

Takeaways from the ASPE Analysis of High-Cost Medicare Beneficiaries

- The top 5% of Medicare FFS beneficiaries account for 40% of Part A/B spending.
- Average per capita spending for the Top 5% is growing faster than for the overall FFS population (3.6% per year).
- Approximately 40% of beneficiaries in the top 5% of Medicare FFS spending remained in the top 10% during the following year.

Additional Takeaway from the Literature Review

- The majority of potentially preventable health care spending is among high-cost beneficiaries.

Goals for PTAC's 2-Day Public Meeting

1. Understand existing effective care models efficiently addressing the needs of this population.
2. Explore opportunities for developing new models that can improve quality of care for high-cost patients with complex chronic conditions or serious illnesses while achieving cost savings.

PTAC Public Meeting Focus Areas

- Providing Patient-Centered Care for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models
- Provider Perspectives on Improving Outcomes for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models
- Best Practices for Measuring Quality and Outcomes Related to Caring for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models
- Optimizing the Mix of Palliative Care and End-of-Life Care in PB-TCOC Models
- Best Practices for Incentivizing Improved Outcomes for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models

Appendix A
Examples of Care Delivery Models for Patients With Complex Chronic Conditions or Serious Illnesses

Current Care Delivery Models/Strategies, Health Maintenance Strategies

Health Maintenance Strategies	
Stanford Model (or Chronic Disease Self-Management Program)	• Patients learn problem-solving, decision-making, and management techniques for physical and psychological effects of chronic disease • Aims to build patients' confidence in managing their own health
Chronic Care Model (CCM)	• Team-based, patient-centered approach that ensures patients have access to community resources, patients receive self-management support, doctors provide care that is guided by scientific evidence, provider roles are clearly defined, and clinical information systems are created that provide timely access to patient data • Applies to a broad range of chronic conditions and settings
Guided Care Model	• Primary care nurse works with an integrated care team to provide coordinated, patient-centered care • Includes in-home assessments, care plans, disease monitoring, care transition management, family and caregiver education, and access to community services
Remote Patient Monitoring	• Allows providers to monitor and manage patients' health from their own home • Data from remote devices are electronically sent to providers for care management

Current Care Delivery Models/Strategies, Team-Based Care Models

Team-Based Care Models	
Chronic Care Model (CCM)	• Team-based, patient-centered approach that ensures patients have access to community resources, patients receive self-management support, doctors provide care that is guided by scientific evidence, provider roles are clearly defined, and clinical information systems are created that provide timely access to patient data • Applies to a broad range of chronic conditions and settings
Patient-Centered Medical Homes (PCMH)	• Comprehensive, patient-centered care coordinated across health care settings • Focus on increasing access to services, shared decision-making, and quality improvement
Care & Learn Model	• Patient-centered approach • Recognizes the need for new research methods for developing, testing, and implementing complex interventions
Program of All-Inclusive Care for the Elderly (PACE)	• Interdisciplinary team designed to meet comprehensive medical and social needs • Aims to keep patients in the community and out of institutionalized settings

Current Care Delivery Models/Strategies, Care Transition Models

Care Transition Models	
Transitional Care Model (TCM)	• Nurse-led intervention that promotes coordination and continuity of care by identifying patient concerns related to the transition process, ensuring medication adherence, assessing patient comprehension of health status and care plan between visits, and using remote health monitoring • Applies to all care transitions (e.g., hospital to home, home to hospital, physician office to home, chronic care to palliative care, and palliative care to hospice care)
Care Transitions Intervention (CTI)	• Short-term model where patients work with a Transitions Coach for 30 days to learn self-management skills for their transition from hospital to home

Current Care Delivery Models/Strategies, Integrated Care Models

Integrated Care Models	
Collaborative Care Model (CoCM)	• Patient-centered team-based care led by a primary care provider; team includes mental and behavioral health professionals • Relies on principles of chronic care delivery
Behavioral Health Integration and Complex Care Initiative	• Support development of health homes that provide integrated physical and behavioral care for medically complex patients • Whole-person approach to address physical, behavioral, social, and environmental needs
Integrated Care Model	• Conceptual model(s) where the idea is to integrate care between the specialists and the palliative care team. • Palliative care is provided to cancer patients earlier in their disease progression (e.g., at time of diagnosis of advanced disease).

Current Care Delivery Models/Strategies, Palliative Care Models

Palliative Care Models	
Integrated Care Model	• Conceptual model(s) where the idea is to integrate care between the specialists and the palliative care team. • Palliative care is provided to cancer patients earlier in their disease progression (e.g., at time of diagnosis of advanced disease).

Appendix B
Additional Information on Care Delivery Strategies

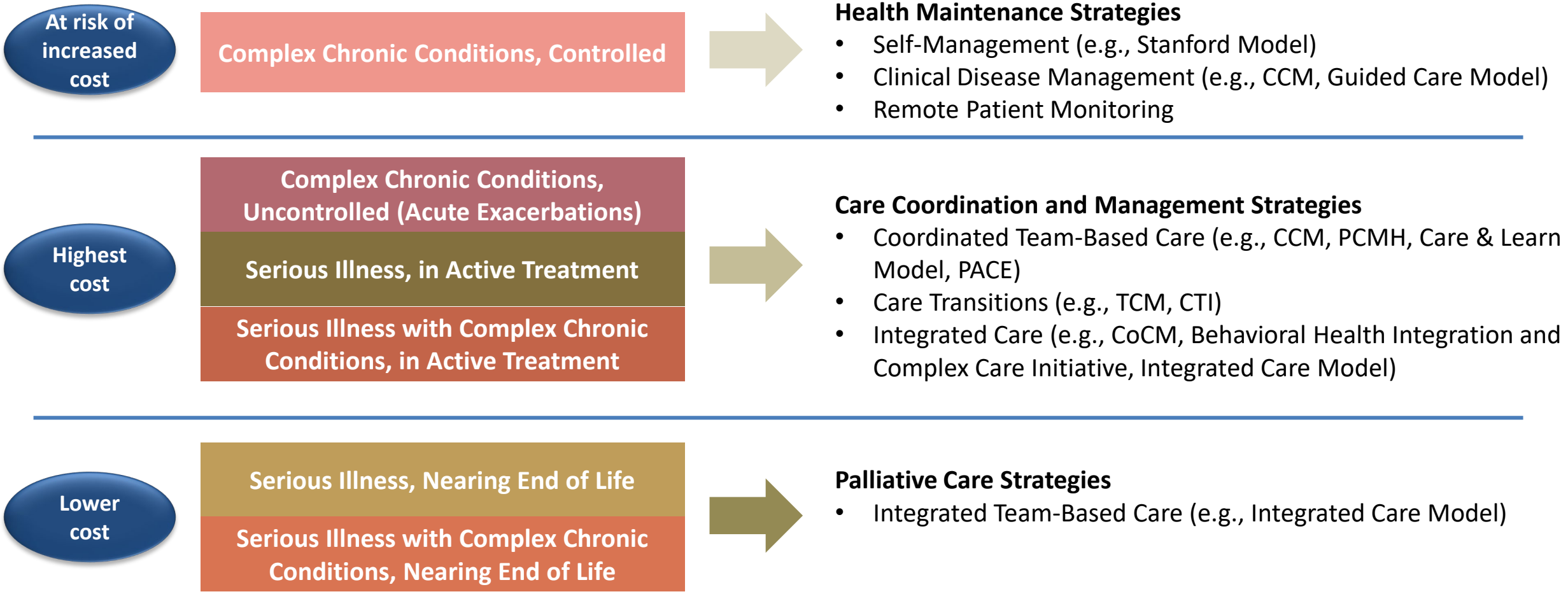
Additional Factors Related to High-Cost Medicare Beneficiaries

- Beneficiary residence type
  - Community residents (living in their own home) have the lowest health care costs
  - Long-term care residents (e.g., retirement/assisted living facilities) have 2 times the health care costs of community residents
  - Nursing home residents have 5 times the health care costs of community residents

- Functional status / activities of daily living (ADL)
  - Half of community residents aged 65+ years have both chronic conditions and functional limitations
  - Among individuals with chronic conditions, those with functional limitations are more likely to be high cost than are those without functional limitations (all ages)

* Based on 2010-2013 data

Care Delivery Strategies for Patients at Different Stages of Disease Progression



Strategies for Patients At Risk of Increased Cost with Complex Chronic Conditions or Serious Illnesses in CMMI Models

Patient Health Category	Strategies	CMMI Models/CMS Initiatives
Complex Chronic Conditions, Controlled	• Chronic disease management • Patient and family/caregiver engagement and education • In-home primary care visits • Care transitions, including medication management • Enhanced provider communication • Financial incentives for quality scores	• Primary Care First • Home Health Value-Based Purchasing • Independence at Home • Medicare Diabetes Prevention Program • Accountable Care Organization Models

Strategies for Lower Cost Patients with Complex Chronic Conditions or Serious Illnesses in CMMI Models

Patient Health Category	Strategies	CMMI Models/CMS Initiatives
Serious Illness, Nearing End of Life	• Creating a more seamless transition to timely hospice care for MA beneficiaries	• Medicare Advantage Value-Based Insurance Design Hospice Benefit
Serious Illness with Complex Chronic Conditions, Nearing End of Life	• Allow simultaneous use of active treatment and hospice care	• Medicare Care Choices Model

Broad Approaches for Targeting Patients with Complex Chronic Conditions or Serious Illnesses in CMMI Models

Population-Based Models that Identify a Subset of Patients with CCC/SI

- Incorporation of care models specific to patients with CCC/SI within a population-based model framework
- Modified payment mechanisms that account for higher-acuity patients
- Use of benefit enhancements
- Examples: Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) High Needs ACOs, MA Value-Based Insurance Design, Program of All-Inclusive Care for the Elderly (PACE)

Disease-Specific Models Focused on Patients with CCC/SI

- Models that aim to address deficits in care for a defined population with a shared disease or medical condition.
- Typically include a financial accountability component
- Patient-centered care for CCC/SI with focus on education and shared decision making
- Examples: Kidney Care Choices (KCC), Guiding an Improved Dementia Experience (GUIDE)

Abbreviations: CCC, complex chronic conditions; SI, serious illnesses

Appendix C
Additional Information on Financial Incentives

Adjusting Payment Models and Financial Incentives in CMMI Models to Account for Patients with Complex Chronic Conditions or Serious Illnesses

CMMI Models	Payment Model Adjustments and Financial Incentives
ACO REACH	• New HCC concurrent risk scores to improve payment adjustment accuracy for beneficiaries with serious or acute illness • Benchmarks calculated separately for patients with ESRD
GUIDE	• Complexity tiers to determine PBPM payments • Higher complexity equals higher PBPM payment
PCF	• Stratification into 4 risk groups using HCC scores • Practices with higher risk scores receive higher PBPM payments

Abbreviation: HCC, hierarchical condition categories; PBPM, per beneficiary per month

Financial Incentives and Payment Models for Patients with Complex Chronic Conditions or Serious Illnesses

Financial Incentive/Payment Model	ACO REACH	CEC	ETC	GUIDE	IAH	KCC	MA VBID	MCCM
Shared savings and losses	X	X			X	X		
Performance-based adjustments	X	X	X	X	X			
Flat payments for infrastructure and services			X	X	X			X
Per beneficiary per month payments				X				X
Capitated payments	X					X		
Expanding coverage to additional services							X	

Appendix D
Characteristics of Selected CMMI Models that Focus on Patients with Complex Chronic Conditions or Serious Illnesses

Key Characteristics of Selected CMMI Models that Focus on Patients with Complex Chronic Conditions or Serious Illnesses

Model	Clinical Focus	Components and Financial Incentives Relevant to Patients with Complex Chronic Conditions or Serious Illnesses
Guiding an Improved Dementia Experience (GUIDE) Model **(GUIDE)**	Dementia	**Overall Model Design Features:** The GUIDE Model is focused on improving dementia care quality through defining a standardized approach to dementia care delivery, providing an alternative payment methodology, addressing unpaid caregiver needs, providing respite services, and screening for Health-Related Social Needs. **Care Coordination and/or Care Transition Approaches:** Comprehensive, person-centered assessments and care plans, care coordination, and 24/7 access to a support line, & care navigators to help access services and supports. Also provides enhanced access to resources for caregivers, such as training programs. **Financial Incentives to Enhance Participation by Providers:** CMS will provide three types of payment: 1) infrastructure payment (safety net providers can receive a one-time infrastructure payment for program development activities), 2) PBPM payment (to provide care management, coordination, caregiver training, and other support services), and 3) respite care payment (providers can bill for respite services).
Medicare Advantage (MA) Value-Based Insurance Design (VBID) **(MA-VBID)**	Chronic Conditions	**Overall Model Design Features:** The MA VBID Model allows MAOs to design benefits based on chronic condition, socioeconomic characteristics, or area deprivation index (ADI). It also incentivizes the use of Part D prescription drug benefits through rewards and incentives (RI). There is also an optional Medicare hospice benefit. **Care Coordination and/or Care Transition Approaches :** Care management programs **Financial Incentives to Enhance Participation by Providers:** MAOs may provide reduced cost sharing to beneficiaries based on chronic condition or socioeconomic status. Also, MAOs may offer rewards and incentives specific to participation in a transition of care program.

Key Characteristics of Selected CMMI Models that Focus on Patients with Complex Chronic Conditions or Serious Illnesses, Continued

Model	Clinical Focus	Components and Financial Incentives Relevant to Patients with Complex Chronic Conditions or Serious Illnesses
Medicare Care Choices Model (MCCM)	Palliative care for beneficiaries with advanced illnesses	**Overall Model Design Features:** MCCM allowed Medicare beneficiaries to receive palliative care from hospice providers (e.g., pain and symptom management, spiritual services, counseling) while still receiving care for their condition or illness from other Medicare providers (which beneficiaries usually cannot receive once they elect to receive hospice services). **Care Coordination and/or Care Transition Approaches:** Information is shared among the participating hospice's interdisciplinary team to ensure the delivery of coordinated care. **Financial Incentives to Enhance Participation by Providers:** Per beneficiary per month (PBPM) payments to participating hospices
Medicare Diabetes Prevention Program (MDPP) Expanded Model	Diabetes (Type 2)	**Overall Model Design Features:** MDPP provides interventions to try to prevent type 2 diabetes in patients with an indication of pre-diabetes. Patients receive 16 "core" sessions over six months focused on dietary changes, physical activity, and healthy lifestyle habits. Core sessions are followed by 6 follow-up sessions over six months. **Care Coordination and/or Care Transition Approaches:** Suppliers do not implement care coordination approaches. Communication with primary care providers is limited. **Financial Incentives to Enhance Participation by Providers:** To incentivize participation, reimbursement rates for core and maintenance sessions were increased in 2022 compared to 2021. Further, providers are incentivized to help patients reach their weight loss goals (e.g., 9% weight loss results in higher reimbursement than a 5% weight loss).

Appendix E
Characteristics of PTAC Proposals that Focus on Patients with Complex Chronic Conditions or Serious Illnesses

Key Characteristics of Selected PTAC Proposals that Focus on Patients with Complex Chronic Conditions or Serious Illnesses

Thirteen of the proposals that have been submitted to PTAC included components related to addressing the needs of patients with chronic conditions and/or serious illnesses. The Committee found that seven of these proposals, of which five are included below, met Criterion 7 (Integration and Care Coordination).

Proposal	Clinical Focus	Components and Financial Incentives Relevant to Patients with Complex Chronic Conditions or Serious Illnesses
American Academy of Hospice and Palliative Medicine	Serious illness and palliative care	**Overall Model Design Features:** PACSSI proposes palliative care medical home services for high-need patients not yet eligible or not wanting hospice care. **Care Coordination and/or Care Transition Approaches:** Use of interdisciplinary care teams; availability of multiple specialists; development of coordinated care plan; use of health information technology (HIT) **Financial Incentives to Enhance Participation by Providers**: Tiered monthly payments to replace E/M payments.
Coalition to Transform Advanced Care (C-TAC)	Advanced illness	**Overall Model Design Features:** ACM proposes advance care planning services through an interdisciplinary team and coordination of care with patients' regular providers. **Care Coordination and/or Care Transition Approaches:** Interdisciplinary teams and comprehensive care management **Financial Incentives to Enhance Participation by Providers**: PBPM payments with potential for quality-based bonus payment. Further, a partial advanced APM incentive where providers with a 75% enrollment of patients with advanced illness will receive a 5% bonus payment for professional fees.

Key Characteristics of Selected PTAC Proposals that Focus on Patients with Complex Chronic Conditions or Serious Illnesses, Continued

Proposal	Clinical Focus	Components and Financial Incentives Relevant to Patients with Complex Chronic Conditions or Serious Illnesses
Hackensack Meridian Health and Cota (HMH/Cota)	Cancer care	**Overall Model Design Features:** Oncology Bundled Payment Program proposes to use Cota Nodal Address (CNA)-Guided Care to diagnose patients and assess treatment needed. **Care Coordination and/or Care Transition Approaches:** Use of the EHR system (Epic) by all participating providers; team of care coordinators within PCP practices; care management module (Healthy Planet) for all patient care plans **Financial Incentives to Enhance Participation by Providers**: Bundled payment to cover all aspects of patients' oncology care
New York City Department of Health and Mental Hygiene (NYC DOHMH)	Hepatitis C virus (HCV)	**Overall Model Design Features:** The Project INSPIRE Model proposes integrated medical, behavioral, and social services for patients with HCV. **Care Coordination and/or Care Transition Approaches:** This model utilizes care coordinators who document HCV treatment, including initiating care coordination, developing a care coordination plan, and attaining sustained virologic response (SVR). **Financial Incentives to Enhance Participation by Providers**: Bundled payment and potential shared savings
Renal Physicians Association (RPA)	End-stage renal disease (ESRD)	**Overall Model Design Features:** The Incident ESRD Clinical Episode Payment Model proposes care coordination and renal transplantation, if applicable, for dialysis patients transitioning from chronic kidney disease (CKD) to ESRD (6 month episodes of care). **Care Coordination and/or Care Transition Approaches:** Care coordination between PCP and specialists, including vascular surgeons; coordinating dialysis care in outpatient settings **Financial Incentives to Enhance Participation by Providers:** Shared savings for the 6-month episode of care; bonus payment for patients receiving a kidney transplant

Appendix F
Characteristics of Chronic Condition Special Needs Plans (C-SNP) that Focus on Patients with Complex Chronic Conditions or Serious Illnesses

Key Characteristics of the C-SNP Program that Focus on Patients with Complex Chronic Conditions or Serious Illnesses

Program	Clinical Focus	Components and Financial Incentives Relevant to Patients with Complex Chronic Conditions or Serious Illnesses
Chronic Condition Special Needs Plans (C-SNPs)	Severe or disabling chronic conditions	**Overall Model Design Features:** C-SNPs are special needs plans (SNPs) for beneficiaries with select severe or disabling chronic conditions. There are 15 chronic conditions for which MAOs can offer a C-SNP in the following ways: 1) for one of the 15 approved chronic conditions, 2) for a predetermined group of conditions that are clinically linked, or 3) for a group of one or more of the conditions as decided by the MAO. **Care Coordination and/or Care Transition Approaches:** Part D prescription drug coverage **Financial Incentives to Enhance Participation by Providers:** MAOs may offer no or lower cost sharing to the beneficiary

Appendix G
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